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ABSTRACT

The report discusses the efforts of the U.S. military services to deal with child abuse and neglect in military families. Child advocacy programs were visited and evaluated along criteria in five areas: prevention and identification, intake and assessment, treatment, followup, and reporting. Fundamental differences in the services' child advocacy programs are described. The Department of Defense (DOD)'s limited involvement with the military child advocacy programs is cited, and obstacles to cooperation between military child advocacy programs and civilian social welfare programs are noted. Among conclusions reported are that each of the three military services has established its own program to deal with child maltreatment without any overall DOD guidance, leading to inconsistent policies. Recommendations made for improving the child advocacy programs include giving greater priority and resources to the programs while increasing education and training efforts. Reporting problems are cited, and a recommendation is made for establishing a single DOD policy concerning reporting procedures. (CL)

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ED176498

BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Military Child Advocacy Programs--Victims Of Neglect

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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Each military service has a child advocacy program for military families. However, inconsistencies in program regulations adversely affect program organization and management. Military installations GAO visited had efforts underway to deal with child maltreatment problems. Most of these could be greatly improved if greater priority and resources were given to child advocacy.

The Department of Defense should establish a small centralized group to develop consistent policies, organization, and management for the services' programs. This group should also develop educational materials to help improve installation-level programs. Also, DOD should develop a single departmentwide policy concerning the collection and use of child maltreatment information.

DOD agreed, but was concerned that budget constraints could inhibit its ability to fully implement the recommendations.

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HRD-79-75
MAY 23, 1979

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-192159

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the military services' efforts to deal with child abuse and neglect in military families. Each service has a child advocacy program, and installations have efforts underway to deal with child maltreatment problems. Most of these efforts could be more effective if greater priority and resources were given to child advocacy.

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretaries of Defense and Health, Education, and Welfare.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

MILITARY CHILD ADVOCACY
PROGRAMS--VICTIMS OF
NEGLECT

D I G E S T

Each military service has established its own child advocacy program without any overall guidance from the Department of Defense (DOD). As a result, child advocacy programs for military families have inconsistent policies on such important issues as

--the appropriate placement of child advocacy programs within the organizational structure of each service,

--age differences in the services' definitions of a child, and

--the organization and management of child advocacy programs at the installation level.

In addition, the services' programs receive no direct funding and, at most installations, suffer from a lack of adequate staff. Also, the child maltreatment reporting systems currently maintained by the individual military services are inconsistent and ineffective for managing maltreatment cases.

The magnitude of child abuse and neglect in the United States is difficult to measure because many incidents go unreported. The National Center on Child Abuse and Neglect estimates that 1 million incidents occur each year. About 2,000 deaths are reported from such incidents annually. Child maltreatment is generally believed to occur as frequently in the military as in civilian society. (See p. 1.)

PROGRAMS LACK SUFFICIENT DIRECTION AND RESOURCES

An indicator of the management attention and resources given to the military's child advocacy programs is the fact that none are directly funded, and they are generally staffed by individuals who have been assigned child advocacy responsibilities as a collateral duty. In that context, the programs essentially serve as administrative mechanisms to use existing resources in dealing with child maltreatment. DOD views its responsibility in the child advocacy area as one of monitoring rather than managing the program. (See pp. 4, 5, and 11.)

The Secretary of Defense should develop, and provide to the services, guidelines that would bring consistent policies, organization, and management to the programs at the headquarters and installation levels. (See p. 21.)

All of the military installations GAO visited had efforts underway to deal with child maltreatment. These efforts had some of the elements of an effective child advocacy program. However, with the exception of providing medical care for physical injuries, all program elements could be greatly improved. (See p. 14.)

GAO believes that improving the child advocacy programs at the installation level will require DOD to place greater priority on and direct more resources to these programs. In the area of child advocacy education, emphasis is needed on programs for all members of the military community aimed at preventing and identifying child maltreatment and establishing procedures to be followed by persons, such as military police, who make the first contact regarding a suspected incident. (See p. 14.)

GAO also believes that additional staff could be used at virtually all DOD installations to carry out the child advocacy responsibilities that are now given to individuals as a collateral duty. However, GAO recognizes that obtaining those resources and effectively working them into the program in a short period could be difficult. Therefore, the Secretary of Defense should establish a small centralized group to serve as a focal point for developing the child advocacy program guidelines and educational and training materials and for communicating with military installations on child advocacy matters. (See p. 21.)

The National Center on Child Abuse and Neglect has told DOD that it would seriously consider providing funds to help establish a small centralized child advocacy group that could perform the above activities as well as others. Such funds could give DOD the capability to begin attacking many of the service weaknesses GAO observed. (See pp. 20 to 22.)

DOD agreed that a central group is needed to develop a common child abuse policy and to monitor and manage military child advocacy programs. According to DOD, its existing Tri-Service Child Advocacy Working Group would provide the nucleus of staff for this effort. However, the members of this group worked only part time on such activities. GAO believes that a small, full-time group is needed to perform these functions. (See pp. 22 and 23.)

The Department of Health, Education, and Welfare commented that it would continue to support DOD's efforts to provide better child protective services to military families. (See p. 23.)

PROBLEMS IN ESTABLISHING EFFECTIVE REPORTING SYSTEMS

Each military service also had a registry for recording and maintaining information

on child maltreatment incidents. With the possible exception of the Air Force's registry, all were incomplete and therefore ineffective for developing meaningful statistics on military child maltreatment problems and maintaining information on prior maltreatment reports that could be used for assessing whether a child is in danger.

The information was incomplete because of poor reporting from military installations. Reporting was poor because individuals were concerned about how this sometimes sensitive information would be used. The practice of maintaining information on suspected abusers was held unconstitutional by a Federal district court in Texas. The Supreme Court has reviewed the case and is expected to rule on this issue during its current term. The Court's decision may affect how DOD as well as civilian social welfare organizations can maintain and use information on suspected abusers in the future. (See pp. 24 29, 31, and 32.)

The Secretary of Defense should develop a single departmentwide policy on the collection and use of information on confirmed and suspected child maltreatment incidents. GAO recognizes that such a policy--as it relates to information on suspected child abusers--should not be developed until the Supreme Court has resolved the legal questions involved. (See p. 32.)

DOD said that establishing a central registry was a critical step in further improving its child advocacy programs. However, it recognized the need to consider the sensitive nature of issues concerning a central registry, particularly as they relate to suspected child maltreatment cases, because that issue is being considered by the Supreme Court. DOD said that it would follow the Court's direction concerning how information in a central registry would be used. (See p. 32.)

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ABBREVIATIONS

BUMED	Bureau of Medicine and Surgery
BUPERS	Bureau of Personnel
CPCMT	child protection and case management team
DCII	Defense Central Index of Investigations
DOD	Department of Defense
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HSC	Health Services Command
OSI	Office of Special Investigations

CHAPTER 1

INTRODUCTION

The Congress has defined child abuse and neglect as the physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child under the age of 18 by a person responsible for the child's welfare under circumstances indicating that the child's health or welfare is harmed or threatened. 1/ As the definition suggests, child abuse and neglect can take many forms. Abuse generally means the beating or excessive chastisement of a child; neglect refers to failure to provide adequate food, clothing and shelter, or emotional care to a child. Child abuse and neglect are commonly referred to as child maltreatment.

The magnitude of the child maltreatment problem is difficult to measure because many incidents go unreported. However, there is little question that the problem is significant. The National Center on Child Abuse and Neglect estimates that 1 million incidents of child maltreatment occur in the United States each year. About 2,000 deaths are reported from such incidents annually; child maltreatment has been reported as the fifth leading cause of death in children of all ages. About 60,000 children end up with significant injuries each year, and about 6,000 of them have permanent brain damage. The lifetime cost of institutional care for a severely brain damaged child has been estimated to be about $700,000.

Although there are no reliable statistics on the subject, it is generally believed that child maltreatment occurs as frequently in the military as in the civilian community. In addition to the pressures that lead to child maltreatment in civilian life, military families face the added pressures of (1) long absences by one parent (especially in the Navy), (2) frequent changes of residence, precluding development of permanent community ties that can aid in preventing or stopping acts of maltreatment, and (3) periods of residence in relatively isolated areas in the United States and in foreign countries. The military services reported about 1,500 cases of child maltreatment in 1977, and they expected about 1,900 cases in 1978. Officials from both the Department of Defense (DOD) and the National Center on Child Abuse and Neglect

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1/Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 et seq.).

believe these figures are considerably understated. Military officials involved in child advocacy programs also believed that a great many incidents were unreported.

Child maltreatment cuts across all segments of society. It is not limited to a single ethnic group or economic level, although economic hardships can trigger acts of maltreatment. Mothers are reported to be abusers as often as fathers. Many abusers were themselves abused as children. Reports indicate that most abusers do not intend to harm their children, but that maltreatment results from the manner in which they respond to the parent-child relationship. It is estimated that as many as 90 percent of all child abusers could be rehabilitated with proper treatment.

In 1975 and 1976, the three military services formally established their own child advocacy programs. In establishing these programs they recognized that the quality of a service member's family life can affect performance, which can in turn affect the morale and discipline of the command. Therefore, attending to the health, safety, and social development of children of military families should be a concern of commanders at all levels. Further, it was recognized that incidents involving brutality, insensitivity, and neglect reflect unfavorably on all members of the military.

SCOPE OF REVIEW

Before starting our review we discussed our overall approach with experts in the area of child maltreatment and reviewed publications and studies on the subject. Through this effort, we identified five basic elements--prevention and identification, intake and assessment, treatment, followup, and reporting--that we believed were essential to a child advocacy program. Criteria within these elements were identified, and after experts on this subject agreed that they were reasonable, we used these criteria to assess the child advocacy programs in the locations visited.

We discussed the DOD's child advocacy efforts with program officials in the Office of the Assistant Secretary of Defense (Health Affairs) and the Offices of the Surgeons General of the Army, Navy, and Air Force. Overseas programs were discussed with officials at Headquarters U.S. Army, Europe; U.S. Air Force, Europe; and U.S. Navy, Europe. We also met with child advocacy program officials at the following installations:

--David Grant Air Force Medical Center, California.

--Lemoore Naval Hospital, California.

--Letterman Army Medical Center, California.

--Oakland Naval Regional Medical Center, California.

--Mare Island Naval Dispensary, California.

--Wilford Hall Air Force Medical Center, Texas.

--Brooke Army Medical Center, Texas.

--Frankfurt, Bamberg, and Permasens Army communities in Germany.

--Royal Air Force, Lakenheath, United Kingdom.

--U.S. Naval Station, Rota, Spain.

We also visited several civilian social welfare organizations in California and Texas to observe how they interacted with the military programs.

Finally, we spoke with officials at the National Center on Child Abuse and Neglect at the Department of Health, Education, and Welfare (HEW) in Washington, D.C., and with officials from Project CARE 1/--an HEW-funded demonstration project involving expanded services and increased coordination between military and civilian child welfare programs in the San Antonio, Texas, area.

1/Designates Project Child Advocacy Resources Expansion.

CHAPTER 2

ORGANIZATION AND OPERATION OF

THE MILITARY CHILD ADVOCACY PROGRAMS

DOD has not provided guidance to the services on child advocacy program content or organization. As a result, fundamental differences exist in the programs that affect their scope of coverage and potential effectiveness. All of the military installations we visited in Europe and California had ongoing programs to deal with child maltreatment problems. Each program contained some elements of an effective child advocacy program. However, with the exception of providing medical care for physical injuries, all program elements could be improved. The areas needing the most improvement were educational programs aimed at preventing and identifying child maltreatment. These improvements would require giving child advocacy programs greater priority and resources.

THE MILITARY CHILD ADVOCACY PROGRAMS

Due to an increased awareness of child maltreatment problems, the military began developing child advocacy programs at the installation level in the late 1960s and early 1970s. By the end of 1976, each service had issued a regulation establishing a formal program.

A leading figure on child maltreatment problems described the military child abuse programs in the following manner:

> "Like those they serve to protect, child protection programs in the military services have sometimes been the victims of neglect. The reasons for this are complex, but in an oversimplification it may be speculated that although no one in the higher echelons of the defense establishment is opposed to good child protection, its importance in maintaining a national defense posture has not been viewed as critical. Clearly these programs have not received the attention given to drug abuse, alcoholism and equal opportunity endeavors, all of which have more direct impact upon active duty troops and military effectiveness."

Perhaps a good indicator of the priority given to the military's child advocacy programs is the fact that none are

directly funded and they are staffed almost entirely by individuals who are given child advocacy responsibilities as a collateral duty. In that context, the programs essentially serve as administrative mechanisms to use existing resources in dealing with child maltreatment.

The Air Force program

Before 1973, several Air Force medical facilities had developed local programs directed toward the medical aspects of child maltreatment cases. An official Air Force program began to be developed shortly after July 1973, when representatives of the Office of the Assistant Secretary of Defense for Health and Environment, 1/ the three military services, and a leading authority on child maltreatment met in Washington to discuss military child maltreatment programs. After the meeting, the Air Force began working on its official child advocacy regulation. The enactment of the Child Abuse Prevention and Treatment Act (Public Law 93-247) in January 1974 provided additional stimulus for the development of the Air Force program, and on April 25, 1975, Air Force Regulation 160-38 was issued. This was DOD's first formally established child advocacy program.

The Air Force program, directed to children under age 21, is managed by the Director of Professional Services in the Office of the Surgeon General. Each major Air Force command has a child advocacy program coordinator, and all medical centers and regional hospitals have senior clinical social workers who serve as consultants for their local programs.

Installation commanders are responsible for overall program operation, and each installation must have a child advocacy committee, which is chaired by the director of medical services or the chief of hospital services. This committee has representatives from the Judge Advocate, personnel, security police, chaplain, and special services offices. The central figure at the installation level is the child advocacy officer, who serves as a liaison between the military installation, nearby civilian social welfare organizations, and the juvenile or family court.

1/In March 1976 this office was designated as the Office of the Assistant Secretary of Defense (Health Affairs).

The Army program

Child advocacy programs were initially established at various Army installations in response to increased awareness of child maltreatment problems. One of the earliest programs began in 1967 at the William Beaumont Army Medical Center near El Paso, Texas. By 1970, about two-thirds of the Army installations in the United States had some procedures for child protection. By 1974, virtually every installation had some type of effort underway.

The Surgeon General became interested in establishing an Army-wide child advocacy program in early 1972, after installation officials asked for guidance from Army headquarters in dealing with a growing number of child maltreatment cases. In February 1972, the Surgeon General appointed a committee to formulate an Army-wide program. Initially, the committee considered establishing the child advocacy effort as a medical program. However, it became convinced that the program should be set up on a broader basis, recognizing both the medical and social aspects of child maltreatment. The Surgeon General's office had completed work on the draft of Army Regulation 600-48 by late 1974, and it was formally issued on November 26, 1975.

The Army program is directed toward all military children under age 18. Overall management of the Army program was initially given to the Deputy Chief of Staff Personnel. However, in early 1977, this responsibility was delegated to the Adjutant General. Army Regulation 600-48 gave specific responsibility for various phases of the program to the following individuals:

--The Adjutant General is to provide resources and technical assistance in conjunction with child welfare services.

--The Surgeon General is to support the program by (1) providing medical care, (2) establishing a system for collecting data on child maltreatment incidents, and (3) supervising aspects of identifying, preventing, and treating child maltreatment.

--The Chief of Chaplains is to provide support along with his other activities relating to service members and their families.

--The Chief of Information is to coordinate the dissemination of information on the program.

--The Judge Advocate General is to provide legal advice.

Installation commanders must establish a child advocacy program at facilities with 2,000 or more dependents living either on or off base. An officer must be designated to monitor and supervise the program. The installation's hospital commander is required to organize and supervise a child protection and case management team (CPCMT) to assist in the evaluation, diagnosis, treatment, and handling of abused and neglected children. The hospital commander must also designate either a social worker or a nurse to receive and act upon all reports of child maltreatment referred to the medical facility.

According to the Army's regulation, a CPCMT must include pediatricians, psychologists, social workers, nurses, and lawyers. It may also include law enforcement personnel, civilian child protection workers, chaplains, occupational therapists, and others who can contribute to the case management process.

The regulation also directs each installation to establish a child advocacy/human resources council. The council's membership is to be determined by the installation commander. The council is responsible for assessing the needs of military children living either on or near the installation and developing various preventive, foster care, and educational programs for the installation's child advocacy effort.

The Army's regulation on the child advocacy program was being revised at the time of our fieldwork. The major changes being considered were:

--Formally transferring program responsibility to the Adjutant General.

--Placing the program under the Army Community Services Program.

--Modifying data collection activities to require reporting of the extent to which cases of maltreatment have been supported by evidence (i.e., alleged, suspected, confirmed, or unfounded).

--Providing specific guidance on establishing and operating a central registry of reported cases.

--Providing more specific direction on the duties and responsibilities of all personnel involved in the program.

The new regulation containing the changes discussed above was issued in October 1978.

The Navy program

The Navy's child advocacy program grew out of the participation by Navy pediatricians in an American Academy of Pediatrics project that looked into the problem of child maltreatment among military dependents. By 1973, a growing number of child maltreatment incidents were being brought to the attention of the Navy, and the Surgeon General became convinced that an official program was needed.

Officials from the Bureau of Medicine and Surgery (BUMED) believed that child maltreatment needed to be addressed not solely as a medical problem, but also as a social problem. With this objective in mind, Navy medical officials attempted to persuade senior Navy officials to designate the Bureau of Personnel (BUPERS) as the organization responsible for the program. Because BUPERS actions affect all Navy personnel, regulations to implement a BUPERS program are issued by the Secretary of the Navy and require Navy-wide compliance. BUPERS questioned whether a serious child maltreatment problem existed and convinced senior Navy officials to deny BUMED's request. As a result, BUMED began organizing its own program in 1974.

While BUMED was considering how its program should be organized, a number of naval medical facilities recognized the need to implement their own programs. By 1975, 12 of 14 naval regional medical centers had child advocacy regulations; the other 2 had established policies to cover child maltreatment incidents. Of the 21 smaller naval hospitals, 6 had a specific regulation; 13 had no regulation, but did have a stated policy; and 2 had neither a policy nor a regulation.

On February 4, 1976, BUMED issued an instruction (BUMED 6320.53) on child advocacy that was mandatory for all medical activities. Under the instruction, the Surgeon General is responsible for establishing broad policies for the Navy's child advocacy program and for establishing the Central Child Advocacy Committee. This committee includes representatives of BUMED, BUPERS, the Office of Judge Advocate General, and the Marine Corps. The committee, which is chaired by a

physician, is responsible for overseeing the Navy's child advocacy program and recommending to the Surgeon General proposals for identifying and correcting child maltreatment problems.

At the installation level, commanding officers of naval medical facilities are also required to establish child advocacy program committees. The commander of the medical facility appoints the committee's chairperson, who serves as the child advocacy representative and the focal point on all matters relating to child maltreatment at the installation. The committee may be composed of representatives from several areas.

- Pediatrics
- Social services
- Nursing
- Judge Advocate
- Psychiatry
- Public affairs office
- Chaplain
- Psychology
- Security
- Navy relief
- Red Cross
- Local dependents' school nurse
- Civil Engineer Corps officer
- Appropriate local civilian agencies

The child advocacy committee meets at least once every 2 months to review suspected child maltreatment cases and evaluate the quality of child welfare services provided. It also develops plans for managing individual and installation child maltreatment problems and reports actions taken to the commanding officer of the medical facility.

A major weakness of the Navy's program is that its implementing regulation is applicable only to medical facilities. Navy nonmedical activities are not required to comply with the regulation, and installation commanders are not responsible for the program. Therefore, installations without extensive medical activities may not have child advocacy programs.

BUMED issued a revised instruction on January 27, 1978, which, among other changes, reduced the age criterion for a child from 21 to 18 years.

DOD'S INVOLVEMENT IN MILITARY CHILD ADVOCACY PROGRAMS

In March 1973, the military section of the American Academy of Pediatrics sponsored a project which recommended that DOD implement a departmentwide program to improve the

recognition, management, and prevention of child maltreatment in the military. Pediatricians from all three services wno belonged to the Academy's military section participated in this project on their own initiative. The project recommended:

--Establishing a central registry for abused children and their parents.

--Developing a directive at the DOD level to establish a consistent method for management of abused children and their families.

--Designating child abuse centers at or near military facilities in the United States that could be used to receive children and, through research, develop more effective methods for recognition, management, and prevention.

--Developing prevention programs at each post or installation in the United States and overseas that has dependent children.

In June 1974, the American Medical Association held a conference on child maltreatment in the military. The Association suggested that DOD convene a group of experts on the subject who would make specific recommendations on how to implement identification, treatment, and prevention programs in the services. The conference report stated that high priority should be given to

--developing a central registry to record and analyze all child abuse reports as a means of assessing the total problem within DOD,

--providing official recognition at the DOD level and at higher echelons of each military service that a problem exists,

--developing a comprehensive regulation that is as consistent as possible among the military services,

--allocating funds and professional personnel in the areas of protective services, and

--providing official recognition at the highest management level that the child advocacy program is mandatory.

Most of the above recommendations have not been implemented, and DOD has allowed the services to implement their own child advocacy programs without any overall guidance. The Assistant Secretary of Defense (Health Affairs) viewed the role of his office in the child advocacy area as one of monitoring, rather than managing, existing service programs. In January 1975, a Tri-Service Child Advocacy Working Group was established to carry out this monitoring role.

INTERACTION OF MILITARY CHILD ADVOCACY PROGRAMS WITH CIVILIAN SOCIAL WELFARE PROGRAMS

The child advocacy regulations of all three services stress the importance of local military and civilian social service programs interacting to assure effective use of all available resources, thereby providing the best possible service to military members and their dependents. Specifically:

--The Air Force regulation states that the installation commander will cooperate and coordinate with local social service and welfare authorities who have responsibility for monitoring similar civilian programs to facilitate obtaining local services where it is considered in the best interest of the military member and/or his dependents.

--The original Army regulation stated that the installation commander will use community resources efficiently for prevention of child maltreatment and that the CPCMT will use and coordinate available military and civilian resources to treat children and families referred to the medical treatment facility. The new Army regulation states that close liaison and cooperation between military and civilian agencies is strongly encouraged to insure comprehensive and effective child maltreatment identification and treatment efforts.

--The Navy instruction directs the commander of medical facilities to support a positive working relationship between the child advocacy programs committee and the local civilian welfare agencies. It also requires the committee or the child advocacy representative to assist civilian agencies in providing services to eligible military families in local civilian communities.

This interaction is intended to expand the military installations' capability to deal with child maltreatment problems. Such interaction permits the installations to use civilian social welfare resources and thereby provide better services than might otherwise be available. Civilian resources are generally not utilized outside the United States because of language barriers and differing laws, customs, and attitudes toward child abuse and neglect in other countries. As a result, the military services in Europe, for example, attempt to deal with all aspects of child abuse and neglect cases, and resort to local assistance only in extreme emergencies. The host countries generally approve of this method because they would prefer that the military services handle their own problems.

The extent of interaction between military and civilian social service organizations varied at the installations we visited in the United States. It was determined partly by the attitudes of the agencies involved and by the availability of resources on the military installations and in the local civilian communities.

One obstacle to effective interaction is the legal relationship between a military installation and the State in which it is located. There are three principal categories of relationships:

1. Exclusive jurisdiction: Those in which military personnel, while on base, are considered to be federalized citizens and subject only to military and Federal laws. State or Federal authorities cannot enforce violations of State law when they occur on these military installations.

2. Concurrent jurisdiction: Those in which both State and military laws apply.

3. Partial and proprietary jurisdiction: Those in which military law is applicable only in areas specified at the time the military reservation was established or in later agreements.

The most troublesome situation involves exclusive jurisdiction, because civilian agencies have no authority regarding child maltreatment incidents occurring on the military installation. In this situation, the following problems can arise:

--Persons with knowledge of maltreatment incidents are not obligated to report them to State authorities unless required to do so by military regulations.

--State welfare agencies cannot voluntarily initiate assistance.

--Military courts have no criminal jurisdiction over dependents of military personnel even if they live on the military installation.

--State courts have no jurisdiction over individuals involved in maltreatment incidents occurring on the military installation.

The kind of jurisdiction often influences whether a child maltreatment case will be handled as a civil or criminal offense, and who may authorize the removal of a child from the home. For example, in an exclusive jurisdiction, a military family that does not live on the installation may be investigated by a civilian social service worker, while a family living on the installation may be investigated by an agent of a military investigative organization or the Federal Bureau of Investigation. If an investigator determines that a dependent mother is responsible for the abuse, a civilian court proceeding may be initiated. If the father is deemed responsible, the case could be heard in the military court as a criminal proceeding.

At Lackland Air Force Base, an exclusive jurisdiction installation, officials developed a procedures manual which dealt with jurisdictional issues in a simple manner. The base commander agreed to allow county welfare workers to come on the base when necessary to provide services to families. The county worker was required to notify the base child advocacy officer of the first visit, but not of other visits to the same family. The advocacy officer informed the base commander of the initial visit, maintained contact with the county welfare worker, and informed the commander when the county worker had completed work with a specific family. This agreement provided a means for military child advocacy officials and county welfare officials to overcome the type of jurisdictional problems referred to above.

According to officials at Project CARE, the existence of separate military child advocacy regulations also created difficulties in achieving effective interaction between military and civilian child welfare programs. These regulations called for different approaches in dealing with child maltreatment and established different organizational groups -

with different responsibilities. These officials stated that the different regulations made coordination between the civilian and military programs difficult and did not offer any other offsetting benefits in dealing with child maltreatment.

OBSERVATIONS ABOUT CHILD ADVOCACY PROGRAMS AT LOCATIONS VISITED

All of the military installations we visited in Europe and California had ongoing programs to deal with child maltreatment problems. Each program contained some elements of an effective child advocacy program; however, with the exception of providing medical care for physical injuries, all could be greatly improved. The areas needing the most improvement were education programs aimed at preventing and identifying child maltreatment. These improvements would require additional resources. 1/

Prevention and identification

Prevention and identification programs are educational efforts aimed at increasing the awareness of and the ability to recognize child maltreatment. Generally, these were the weakest elements of the installation programs we examined, and they could benefit the most from additional resources.

Prevention programs

The broad objective of prevention is to stop child maltreatment before it occurs. Vigorous prevention programs are needed at DOD installations to assist the military families which, in many cases, are separated from their extended families 2/ and other civilian resources that families rely on for support and assistance. Effective prevention programs should be directed toward parents and be designed to help strengthen family life and improve parental skills. These programs should instruct parents that they can get help when they need it and develop community support for prevention activities.

1/On June 26, 1978, we sent a letter report to the Commander in Chief, U.S. Army, Europe, containing our detailed observations on the child advocacy programs at the Army installations we visited in Europe.

2/The extended family generally refers to relatives of the husband and wife, including brothers, sisters, parents, grandparents, cousins, aunts, and uncles.

The effectiveness of the prevention programs we visited varied. The naval facility at Rota, Spain, did not have an overall educational program aimed at preventing child maltreatment. The only publicity given to child maltreatment was a taped radio spot broadcast daily over the Armed Forces Network radio. This broadcast did not include certain fundamental information, such as a telephone number where help could be obtained. Officials at Rota were preparing a newcomers' briefing to be used by all military units, but child advocacy information was not being included. Public forums, such as community meetings, were tried at Rota, but they were discontinued because of a lack of interest. The base commander held weekly meetings during which any topic could be discussed; child maltreatment had not been discussed at the time of our fieldwork.

Three Army communities in Germany had implemented certain educational efforts. The efforts included occasionally discussing child maltreatment at Parent Teachers Association meetings and informing newly assigned personnel about the local child advocacy programs. These efforts tended to be infrequent, were made on an ad hoc basis, and did not appear likely to reach parents in stress or crisis situations. According to Army officials, a shortcoming in prevention has been the lack of publicity about the program's existence at these three installations and the lack of information about where to obtain assistance. The prevention effort at these Army communities was also hampered by the fact that all CPCMT members were assigned child advocacy program responsibilities on a part-time basis and much of their time was devoted to crisis intervention and case management.

At the Air Force installation in Lakenheath, England, the prevention program was much stronger than at the other European locations visited. For example, British welfare representatives had participated in a seminar for expectant mothers addressing stresses commonly faced in raising children; the British Health Services had made home visits to discuss general family problems; and the chaplain's office had given parent effectiveness training.

Three of the five military installations we visited in California had no organized child maltreatment prevention programs. Certain weaknesses existed at the two installations that had programs. For example, Letterman Army Medical Center had to discontinue parent effectiveness training because of budget cuts. Program officials hoped to have it reinstated in the near future. Also, although Travis Air Force Base had a 24-hour hot line, it was not publicized as being a part of the program.

Identification programs

Identification programs are educational efforts directed toward recognizing signs of possible child maltreatment and reporting suspected cases to the proper officials. To be effective, these programs must convey an understanding of what constitutes child maltreatment to professionals having frequent contact with children, such as physicians, nurses, and school teachers, and to the public. Educating nonmedical personnel is important because studies show they report a significant portion of all cases identified at military installations. For example, nonmedical personnel reported nearly 50 percent of all the cases (1) at the William Beaumont Army Medical Center near El Paso, Texas, between September 1967 and December 1973 and (2) involving military families in San Antonio, Texas, from June 1974 to May 1975.

Identification training programs should be conducted on a continuing basis because of personnel turnover and the need to reinforce knowledge of how and when to report incidents. Servicewide regulations encourage all military and civilian personnel to report child maltreatment cases. However, individuals involved in child advocacy programs at DOD headquarters have expressed concern that the number of cases reported may be significantly less than the actual incidence of military child maltreatment because of inadequate identification programs at military installations.

The services' identification programs were not usually directed toward all members of the military community. At installations in California, medical personnel were receiving identification training, but only occasional efforts had been made to educate such nonmedical personnel as security police, chaplains, school teachers, and line officers.

The extent of educational efforts on identification varied at the European military installations. No child maltreatment identification training had been given to persons most likely to encounter child maltreatment at the naval installation in Rota, Spain. One child advocacy officer said he periodically published an article on child maltreatment in his unit's daily bulletin that included his name and telephone number. This was the only publicity on how to report suspected cases.

The naval facilities in the United Kingdom had done little to publicize where and how to report child maltreatment cases. Officials involved in the program and some persons who have frequent contact with children know how to

report cases. Others received little information on a continuing basis. Public information efforts for the identification phase were practically nonexistent at the Army facilities we visited in Germany. Military personnel were not being made aware of how to report suspected child maltreatment cases. Many members of the Army communities agreed that training was needed to help them identify child maltreatment cases.

Intake and assessment

Intake and assessment refer to the actions that take place from the time installation personnel are notified of a possible child maltreatment case until the case is evaluated by the installation committee. This function is intended to receive and enter into the system suspected child maltreatment cases, assure the immediate safety of the child, provide any needed emergency services, evaluate the case, and recommend appropriate treatment.

The intake and assessment function should be capable of receiving reports of possible incidents at any hour of the day or night, responding immediately with emergency services to protect a child from further harm, and relieving pressures on critical family situations. Even in nonemergency situations, initial contact with the family should be made within 24 hours of the reported incident.

Although each military facility we visited had procedures covering the intake and assessment of suspected child maltreatment cases, we noted certain weaknesses. For example, at one Army installation in California, the military police get involved in about one child maltreatment case each month. However, they have not received periodic instruction on the procedures to be followed during the intake and assessment phase of the program. The commanding officer of the military police detachment informed us that he has had only half a day every other month to brief the detachment on military police duties at the post. Because of its low priority, the child advocacy program is not covered during these briefings. As a result, the military police may not be familiar with procedures dealing with suspected child maltreatment cases.

At three Army communities we visited in Germany, no child advocacy program official was designated to respond to suspected cases after duty hours. At these locations, a suspected child maltreatment case might not be responded to until the following day.

The naval facility in Rota, Spain, had an informal system for receiving and responding to suspected child maltreatment cases within 24 hours after the initial report. However, written procedures had not been established

Treatment

Treatment programs provide medical care for the abused child and therapy and counseling for the family. One expert recommends that the entire family be treated as a unit and that efforts be made to improve interactions and relationships within the family.

Treatment for the child

The first priority is to provide immediate care for a child's physical injuries. This is usually short-term care; however, additional care might be needed to treat any long-term or permanent physical or psychological problems.

Foster care for the child is sometimes necessary in very serious incidents. Separating the child and family for a specified period removes stress and takes the child out of the negative environment. The child's accommodations during the period of separation should provide for his or her safety and health and provide a home living environment if possible. Residential housing for foster care, for example, is preferred to an institutional or dormitory setting.

At the installations we visited, the ability to provide crisis care appeared adequate for treating the child's physical injuries. However, improvements were needed in providing foster care and counseling. For example, the naval facilities in Spain, Italy, and England had no foster care programs. In one case at Rota, a child had to remain in the hospital rather than in a home environment during a period of separation. The child was released to the parents when counseling was started.

The Army installations in the Frankfurt area have a child psychiatric clinic, which is an important treatment facility for children. However, it had a limited staff to devote to child advocacy matters. The youth health center, another facility serving adolescents, had become a nonbudgeted Army activity, which means installation officials had to reallocate other budgeted funds to keep it operating. The center's continued operation was in question at the time of our visit.

Treatment for the family

The primary objective of this treatment is to protect the child from further harm by helping the mother and father become better parents. The main goal in working with the parents should be to help them change their abusive or neglectful pattern to one which is more rewarding to both the family and the child. This therapy usually takes 1-1/2 to 2 years and requires multidisciplinary professional help. At the locations we visited in Europe and California, very little effort was being directed toward providing this treatment because of a lack of professional staff resources and some commanders' reluctance to release people for this treatment.

Followup

Followup programs provide a means of checking on the family situation after treatment to assess the effectiveness of services and to determine whether more help is needed.

Some followup was being done at all of the installations. For example, when a family that has been involved in a child maltreatment incident is transferred from Rota, the hospital sends a case summary to the gaining organization. The gaining organization is expected to acknowledge receipt of this report. We were told, however, that the lack of social workers and medical staffs' heavy workloads had limited the effectiveness of Rota's followup program.

Navy medical officials in the United Kingdom also said that the lack of resources had precluded them from following up on child maltreatment cases. They said that, because the Navy had not been able to provide followup services in the London area, most families with child maltreatment problems were transferred to the United States.

At the three Army communities in Germany, followup generally involved monitoring the case while the family resided in the military community and forwarding case information to the gaining installation. Monitoring was done through counseling sessions and during family visits to the medical facility. One military community, however, was not assuring that case information was forwarded, and the case files of the other two communities lacked sufficient data to initiate followup action. As a result, considerable effort would be required to obtain needed data for a particular case.

At the Air Force Base at Lakenheath, England, followup is generally the responsibility of the organization providing treatment. Pediatricians periodically examine the child and discuss the case with the parents; the family children clinic or British authorities also made home visits. Occasionally, others may provide followup. For example, a school counselor or nurse may be asked to monitor the child during school hours. The Lakenheath case files generally contained comprehensive information on followup actions. Lakenheath procedures provide for forwarding case information to the gaining organization upon transfer.

The chief of pediatrics at one of the naval installations we visited in California said that, when an individual who has been involved in child maltreatment is transferred to the jurisdiction of another Navy hospital, the records are supposed to be forwarded to the commanding officer of the gaining hospital. This official was concerned, however, that the abuser is not required to report to the gaining hospital for additional treatment.

POTENTIAL FOR ESTABLISHING A MILITARY CHILD ADVOCACY RESOURCE GROUP

At its April 1978 meeting, the Tri-Service Child Advocacy Working Group discussed the potential for establishing a national resource center for child abuse in the military. The resource group would have a staff of about six individuals. Among the resource center's objectives would be:

--To establish a worldwide child advocacy communications network among military installations and civilian social service agencies.

--To collect, document, and disseminate information on promising practices developed by military child advocacy groups.

--To collect, adapt to the requirements of the military child advocacy environment, and disseminate child protection research results and promising practices in civilian child protective services.

--To document and disseminate models for military-civilian agency collaboration in child protective services, suitable for differing resource environments.

--To provide technical assistance and training for both military and civilian agency personnel involved in preventing and treating child maltreatment among military families.

The National Center on Child Abuse and Neglect has told DOD that it would seriously consider providing initial funding for such a center.

CONCLUSIONS

Each of the three military services has established its own program to deal with child maltreatment problems without any overall DOD guidance. This approach has led to inconsistent policies within the programs regarding several important issues, such as (1) the appropriate placement of child advocacy programs within the organizational structure of each service, (2) age differences in the services' definitions of a child, and (3) the organization and management of child advocacy programs at the installation level. All of the locations we visited had efforts underway to deal with child maltreatment problems. These efforts had some elements of an effective child advocacy program. However, with the exception of providing medical care for physical injuries, all program elements could be greatly improved.

We believe DOD should develop and provide to the services guidelines on the organization and structure of the services' child advocacy programs. Also, the overall responsibility for the Navy's child advocacy program should be raised to a high enough level to include all naval installations and medical and nonmedical personnel. Failure to act in this area could deny certain families program benefits.

In addition, DOD should provide the services with guidance on how to coordinate their child advocacy programs with civilian social welfare organizations, particularly where exclusive jurisdiction installations are involved. Experience at Lackland Air Force Base showed that a working relationship between military and civilian child welfare organizations can be developed and many problems can be solved.

At the military installation level, improving the child advocacy programs will require giving greater priority and resources to these programs and increasing education and training efforts. In education and training, emphasis needs to be placed on such items as (1) programs for all members of the military community aimed at preventing and identifying child maltreatment and (2) procedures to be followed by persons, such as military police, who make the first contact regarding a suspected incident. In the area of resources, additional staff could be used at virtually all DOD installations to carry out child advocacy responsibilities

that are now given to individuals as a collateral duty. However, we recognize that obtaining those resources and effectively working them into the program in a short period could be difficult. Therefore, we believe that a reasonable approach at this time would be to establish, within DOD, a small group of individuals who could serve as a focal point for standardizing the services' guidelines, developing education and training materials, and communicating with military installations regarding child advocacy matters. This group could be expanded as the scope of its activities warranted. The potential for establishing such a group--possibly with initial funding assistance from the National Center on Child Abuse and Neglect--has been discussed by the Tri-Service Child Advocacy Working Group.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

To improve the organization and operation of the military services' child advocacy programs, we recommend that the Secretary establish a small centralized group to serve as a focal point for:

--Bringing consistency to the services' child advocacy regulations.

--Developing education and training materials for improving child advocacy programs at the installation level.

--Providing guidance to the services regarding how to handle the difficulties posed by exclusive jurisdiction installations when dealing with child maltreatment problems.

--Communicating with military installations and the National Center on Child Abuse and Neglect regarding child advocacy matters in general.

In addition, the Secretary of Defense should direct the Secretary of the Navy to place responsibility for its child advocacy program at a high enough level to encompass all Navy installations and personnel.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on our report, DOD generally agreed with our conclusions and recommendations, stating that the services need common child abuse policies and that a central

group is needed to effectively monitor and manage the program. DOD said that the Tri-Service Child Advocacy Working Group could provide the nucleus of staff for this effort and be responsible for overseeing the program, developing a single directive, and investigating further the potential for support from the National Center on Child Abuse and Neglect.

We are concerned that the Tri-Service Child Advocacy Working Group in its present form would not be able to devote enough time and effort to solving child advocacy problems and provide regular assistance to individuals involved in headquarters and installation child advocacy programs because

--it lacks the authority to direct the services to comply with program requirements,

--it meets only occasionally, and

--its members serve on a part-time basis and have other responsibilities on the staffs of the Surgeons General.

We continue to believe that the child advocacy programs warrant--as a minimum--a small centralized group of full-time individuals at the DOD level to serve as the program's focal point. We believe such a group could provide better management and guidance to the program.

DOD also commented that obtaining the necessary personnel and financial support to improve the child advocacy programs could be difficult because of budget constraints and because these programs do not directly contribute to DOD's main mission of supporting active duty forces. We recognize the difficulties imposed by budget constraints; however, we also believe that child advocacy deserves higher priority and warrants greater resources than it has received in the past. With that in mind, we urge that a concerted effort be made to identify and obtain resources to strengthen these important programs.

HEW said that its National Center on Child Abuse and Neglect would continue to support DOD and the three services in their efforts to deliver better child protective services to military families.

CHAPTER 3

MILITARY CHILD MALTREATMENT REPORTING SYSTEMS

The child maltreatment registries currently maintained by the individual military services are incomplete and ineffective for developing meaningful statistics on military child maltreatment problems and for maintaining information on prior maltreatment reports that could be used for assessing whether a child is in danger. Two medical professional organizations have called upon DOD to establish a tri-service central registry, and the three Surgeons General have said one was needed; however, none has been established. We believe it would be very difficult at this time for DOD to obtain the necessary reporting from all military installations to establish a comprehensive registry because of reluctance at the installation level to report child maltreatment incidents. This reluctance stems primarily from concern about how this sometimes sensitive information would be used.

Further, the practice of maintaining and using information on suspected abusers (i.e., individuals with a prior history of involvement in child abuse and neglect but without a judicial determination of abuse and neglect against them) was held unconstitutional by a Federal district court in Texas. The Supreme Court has reviewed this decision and is expected to rule on this issue during its current term. The Court's decision may affect how DOD as well as the civilian social welfare organizations can maintain and use information on suspected abusers in the future.

WHAT IS A CHILD MALTREATMENT REGISTRY?

A child maltreatment registry is essentially a repository--either computerized or manual--for recording and maintaining certain information on suspected or confirmed child maltreatment cases. 1/ It serves two purposes. First, it can provide the capability to identify individuals previously involved in child maltreatment incidents. Second, it can accumulate statistics on the incidents reported. The ability to identify individuals with a history of child maltreatment is helpful for identifying and evaluating new incidents, especially because military beneficiaries move

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1/In order to comply with the Privacy Act (5 U.S.C. 552a), which took effect in September 1975, each military service published a notice in the Federal Register of the existence of its registry.

frequently and can obtain medical care from several different military hospitals. Knowledge of prior reports of maltreatment can also assist in determining appropriate treatment for both the child and the parents. The accumulation of data on the incidence of child maltreatment would help DOD identify trends and justify resources for a more effective child advocacy program.

THE EXISTING MILITARY REGISTRIES

The military services now maintain their own manual registries. In addition, the Air Force uses the Defense Central Index of Investigations (DCII), a DOD computerized system, to store information on suspected child maltreatment cases.

The Air Force registries

Of the three services, the Air Force maintains the most comprehensive system for keeping track of child maltreatment problems. This system consists of a computerized registry for recording suspected child maltreatment cases and a manual registry for recording confirmed cases.

The computerized registry

The Air Force reports suspected child maltreatment cases to DCII through its Office of Special Investigations (OSI). The Air Force uses DCII to store identifying information (i.e., case number, social security number, and last name) on suspected child maltreatment cases. OSI files these case histories in its manual files, which are separate from those maintained by the Office of the Surgeon General (described on p. 27) and the OSI files on criminal cases.

The criminal investigative agencies of the three services use DCII to store information on criminal cases being investigated. Only designated DOD investigative organizations have access to DCII. The Air Force OSI, the Army Investigative Division, and the Navy Investigations Service are the principal users of DCII. Some child maltreatment cases fall into the criminal category, and these cases for all three services would be included in DCII as criminal cases whether or not DCII was used for suspected child maltreatment cases. The Air Force program director believed that using OSI to access the DCII information helps to safeguard the privacy rights of the suspected abusers and assures that information is not misused.

The Air Force uses the following process to screen suspected child maltreatment cases.

1. When a suspected case is identified at an installation, the base OSI staff is notified.

2. The OSI staff sends a telegram to OSI headquarters, Washington, requesting it to determine whether the suspected abuser has prior reports of suspected maltreatment. Pertinent identification information (i.e., name, date of birth, and social security number) is included in the request.

3. OSI headquarters staff takes the information from the request and enters it into a computer terminal which is connected with the DCII computer. The automated system scans the entire computer file and attempts to match the information from the request with the computer records. The OSI terminal has a viewing screen which displays the information. The information is reproduced on paper if a match is found.

4. When a match occurs, the OSI staff uses the case number identified to research its manual files of reports received from base OSI personnel to verify that the matching information does pertain to prior reports of suspected child maltreatment.

5. When the OSI staff verifies that it has a previous report of suspected child maltreatment on record, it forwards this information by telegram back to the OSI staff at the installation. The OSI staff then gives the information to the child advocacy officials.

Air Force officials said that the process described above could be done in 1 day. However, entering information into the DCII computer generally takes about 7 days. This process essentially involves keypunching the required information on computerized punch cards from narrative reports submitted by the base OSI staff, delivering the cards to the Defense Investigative Service in Washington, and keying the information into the computer.

One drawback of using DCII as a central registry is that it is basically a system for accumulating information on suspected criminal cases. Child advocacy proponents insist that child maltreatment is a social problem, not a criminal one,

and that commingling child maltreatment cases and criminal cases is inappropriate and may inhibit reporting. Several military officials were reluctant to report suspected cases to OSI because they feared that placing a person's name on file with criminal cases might attach a certain stigma to the person.

The manual registry

At the installation level, a committee representing various staff organizations reviews all suspected child maltreatment cases to determine whether they should be classified as confirmed. For a confirmed case, installation officials prepare and forward an Air Force Form 120 to the Air Force Surgeon General's office in Washington, where the case is entered into that office's manual registry. This registry provides Air Force program officials with information on the number and location of confirmed cases. According to the child advocacy program manager in the Surgeon General's office, about 60 percent of the suspected cases are eventually confirmed. From April 1975 to January 1978, installations reported 861 confirmed cases of child maltreatment to the manual registry.

The Air Force headquarters program manager said that restricting the manual registry to only confirmed cases reduced the likelihood of any legal action by persons suspected of child maltreatment for invasion of privacy or other reasons. He believed, however, that an effective central registry should contain information on both confirmed and suspected cases.

The Army registry

The Army's registry for child maltreatment reports is of little value in monitoring maltreatment problems. The Army's child advocacy regulation required that summaries of confirmed cases be prepared and forwarded to the Health Services Command (HSC) at Fort Sam Houston, Texas. 1/ A February 1977 Army Inspector General report criticized the way the Army implemented its registry because implementing instructions were inadequate. The report noted that (1) an effective data base was not being established because reports were being received

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1/The regulation does not require information on suspected cases to be forwarded to HSC. However, such information is retained at the installation level.

in varying formats and (2) HSC had not attempted to issue implementing instructions requiring all installations to report child maltreatment. Army headquarters officials told us that installation child advocacy personnel were reluctant to report cases to the registry because they did not want to be involved and because of privacy considerations.

In a summary characterized as a provisional review of child maltreatment cases, HSC reported 1,087 child maltreatment cases for 1975 through 1977. This information was obtained by canvassing social workers at the Army installation level. It included suspected and confirmed cases but did not include all cases because some installations failed to provide information.

Headquarters child advocacy officials said that additional problems with the Army registry were that (1) it was located at Fort Sam Houston, Texas, and not readily accessible to the Surgeon General's staff who direct the program at the headquarters level and (2) HSC authority to require reporting does not extend to Army hospitals in Europe.

The Navy registry

The BUMED Central Child Advocacy Committee maintains the Navy's manual registry, which includes both confirmed and suspected cases. For confirmed cases, the reports contain detailed information (name, date of birth, address, and social security number) on the abuser and victim along with an explanation of the incident and a summary of recommendations made and action taken by the installation child advocacy committee. For suspected cases the reports include only the identification of the abuser and victim and a summary of the incident.

BUMED Instruction 6320.53A and certain overseas command regulations require installation committees to submit reports of suspected and confirmed cases to the Central Child Advocacy Committee, which in turn uses this information to

--compile overall statistics on the incidence of child maltreatment in the Navy and

--review the details of child maltreatment incidents and recommend to BUPERS the names of Navy families that should not be transferred to overseas locations.

Navy headquarters officials said that some installation officials have been reluctant to report cases, fearing that, once reported, information on the incidents could be incorporated into the service members' personnel files and jeopardize their Navy careers.

Navy medical facilities reported a total of 333 suspected and confirmed cases in 1977. This represents an increase over the 245 reported cases in 1976; however, Navy officials believe it is still far below the true incidence rate. The Central Child Advocacy Committee has been concerned about an apparent imbalance between the number of Navy and Marine Corps cases recorded. In August 1977, of all cases reported, about 43 percent were from the Marine Corps and 57 percent from the Navy. However, the Navy has four times as many dependent children as the Marine Corps.

REPORTING PROBLEMS AT THE INSTALLATION LEVEL

Officials at the field locations we visited said that many child maltreatment cases go unreported. The primary reason is apparently a concern that the information could be used to the detriment of the service member's career.

For example, a program official at one Army hospital in California said that he did not know what happened to the information reported to the Army's registry. He said that information on some cases had been inappropriately disclosed or misconstrued in such a way as to damage careers. As a result of such disclosures, the hospital had stopped sending reports to the Army's registry. A February 1977 Army Inspector General report indicated that Army social workers were not supporting the Army's registry because they did not know how the information was used.

Certain Army facilities we visited in Europe submitted reports inconsistently and sometimes long after cases had been evaluated and treated. Officials at one installation said that they forwarded reports directly to HSC in San Antonio, Texas, without channeling them through medical program coordinators in Europe. Other facilities had forwarded reports only on confirmed or highly suspected cases. In many instances, the information reported from European installations was inconsistent or incomplete. For example, some reports did not have information on the individuals involved and pertinent details on the incident, treatment, and final case disposition. Other reports were vague about how the cases were categorized and what types of treatment were provided.

Although each Navy hospital we visited sent reports of confirmed cases to the Navy registry, installation medical officials did not know how the reports are used at BUMED.

Between April 1975 and December 1977, seven Air Force medical facilities did not report any cases of child abuse and neglect. One Air Force installation visited in California submitted reports of confirmed cases through command channels to the Air Force Office of Surgeon General. Installation officials believed the reports were used for program evaluation--and not for inclusion in the Surgeon General's central registry. The OSI detachment at this installation reports suspected, unsubstantiated cases for input to DCII only if the child advocacy committee requests that they be reported. The committee determines if cases are suspicious on a case-by-case basis.

Most child advocacy officials said that, because of other duties and time constraints, they concentrated on crisis intervention and case management rather than reporting. Several factors that hampered their ability to handle reporting duties follow:

--Individuals who did understand the reporting requirement tended to assume that other individuals had taken care of preparing and forwarding case summaries.

--For certain cases, establishing whether child maltreatment was suspected or confirmed was difficult.

--There was a lack of administrative support to prepare and forward complete, timely case management summaries.

EFFORTS TO ESTABLISH A TRI-SERVICE CENTRAL REGISTRY

In March 1973, the military section of the American Academy of Pediatrics recommended that DOD establish a central tri-service registry for reports on military child maltreatment. A June 1974 American Medical Association symposium on child maltreatment in the military recommended that DOD develop a central capability for recording and analyzing all child maltreatment reports in order to assess the total problem within DOD. At a July 1975 meeting the three Surgeons General agreed that a single DOD central registry was required and that a common format should be used by the services to report incidents. However, a central registry has still not been established. While the professional organizations as

well as the three Surgeons General called for a central registry, none of them specifically addressed the issue of whether it should maintain information on suspected as well as confirmed cases.

Maintaining information on suspected cases in a central registry is a particularly sensitive issue because of a considerable reluctance to report this information. Also, a Federal district court in Texas has held that maintaining and using information on suspected child maltreatment cases without a judicial determination of abuse or neglect is a violation of due process of law and an individual's right to privacy. 1/ As a result of that decision, the State of Texas stopped including information that could identify a suspected abuser (i.e., name and address) in its central registry. An official from the State Department of Public Welfare said that some information is still gathered to maintain statistics on the incidence and type of child maltreatment, but the central registry is of little value now as a mechanism for identifying individuals with a past involvement in child maltreatment. The Supreme Court has reviewed the Texas decision and is expected to rule on this issue during its current term.

Our discussions with medical personnel and other officials involved in child advocacy programs suggest that the value and usefulness of a central registry for identifying and assessing child maltreatment incidents are greatly enhanced if suspected cases are included. On the other hand, it is the inclusion and use of suspected cases that is being legally challenged and seems to greatly inhibit reporting in DOD because of concern that this sometimes sensitive information could be inappropriately used and damage an individual's career.

CONCLUSIONS

The child maltreatment registries currently maintained by the individual military services are incomplete and ineffective for developing meaningful statistics on military child maltreatment problems and for maintaining information on prior maltreatment reports which could be used for assessing whether a child is in danger. We believe it would be very difficult at this time for DOD to obtain the necessary reporting from

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1/Sims v. State Department of Public Welfare of Texas, 438 F. Supp. 1179 (S.D. Tex. 1977).

all military installations to establish a comprehensive registry because of installations' reluctance to report child maltreatment incidents. This reluctance stems primarily from concern about how this sometimes sensitive information would be used.

Maintaining and using information on child abuse incidents, particularly when it involves suspected abusers, is an extremely sensitive issue. The intended use of this information--to identify and reduce child abuse and neglect--is appropriate. By the same token, there is a potential for misuse of the information; and in a Federal district court decision, it has been considered to be a violation of due process of law and the privacy rights of individuals to use this information without a judicial determination of abuse or neglect.

The Supreme Court has reviewed the district court decision and is expected to rule on this issue during its current term. The questions before the Court are complex, difficult, and sensitive, and the Court's decision may affect how DOD as well as civilian social welfare organizations maintain and use information on suspected abusers in the future.

RECOMMENDATION TO THE SECRETARY OF DEFENSE

Because of the sensitive nature of child maltreatment information, the differing reporting systems maintained by the three military services, and the reluctance of persons to report child maltreatment incidents, we recommend that the Secretary establish a single DOD policy concerning the collection and use of information on suspected and confirmed child maltreatment incidents. We recognize that such a policy--as it relates to information on suspected child abuse incidents--should not be developed until the Supreme Court has resolved the legal questions involved.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on our report, DOD said that the services' registries are being upgraded and that establishing a central registry was a critical step in improving the program. DOD recognized the need to consider the sensitive nature of issues relating to the central registry and individual rights of privacy and freedom of information, particularly in the area of suspected cases, because the Supreme Court is considering

this issue. DOD said it would follow the Court's decision regarding how information in its central registry would be used.

We believe that, after the Supreme Court has ruled in the case, DOD should act to insure that the three services follow the same policies and practices for collecting and using this information.

APPENDIX I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

AUDIT AGENCY

MAR 31 1979

Mr. Gregory J. Ahart
Director, Human
Resources Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Military Child Advocacy Programs: Victims of Neglect."

The Assistant Secretary for Human Development Services advises that, the findings and recommendations of this report are consistent with the observations of the National Center on Child Abuse and Neglect (Children's Bureau, Administration for Children, Youth and Families, Office of Human Development Services). The National Center on Child Abuse and Neglect will continue to support the Department of Defense (DOD) and the three Services in their efforts to improve the delivery of child protective services to military families. The active participation of DOD on the Federal Advisory Board on Child Abuse and Neglect allows for continuing communication and collaboration between DOD and DHEW on this issue.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

APPENDIX II

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

11 APR 1979

Mr. Gregory J. Ahart
Director, Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

This is in response to your letter of February 8, 1979 to the Secretary of Defense concerning "Military Child Advocacy Programs: Victims of Neglect" (OSD Case #5093) (Code 10195).

In general, we agree with the report and its recommendations. It correctly perceives child abuse as a matter for serious concern, one in which the DoD has had a very limited role and in which the Military Departments and their medical departments have made varying progress through often differing routes and with varying levels of official support. Despite this, considerable progress has been and continues to be made. Reporting is improving; the registry systems are being upgraded; the new Army Regulation has been issued; and the Navy has conducted a major family advocacy meeting to highlight and improve the program.

We do agree that further steps are in order to enhance the spread, emphasis and effectiveness of the Defense Child Abuse Program. The critical ingredients for further progress are:

(1) Common child abuse policy,

(2) A central body to monitor and manage the Program,

(3) Increased departmental support, both in Washington and at field levels, to the extent that it does not now exist,

(4) A central registry, and

(5) Increased personnel and dollar support to:

a. Support central management,

b. Support and staff a central registry, and

c. Provide more dedicated individuals working the problem in the field.

We agree that the Tri-Service Child Advocacy Working Group is the logical body to form the nucleus for this effort, for expert central program oversight, for development of a directive and for further investigation of support of a central group and a central registry by the National Center for Child Abuse and Neglect, Department of Health, Education and Welfare. We have initiated actions to that end.

The matter of personnel and financial support will be difficult in this time of fiscal restraints and in a program which, while important, does not directly contribute to Defense's main mission of supporting the active duty forces. It may be necessary, as a practical matter, for the Program to continue gradual growth rather than making a quantum advance.

The matter of a central registry and the privacy and freedom of information aspects of it, particularly in cases of suspected abuse, will have to be handled judiciously and with great delicacy. The actions of the courts in this regard will be followed.

Sincerely,

V. McKenzie

Vernon McKenzie
Principal Deputy Assistant Secretary

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